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CONTENTS.

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CLINICAL NOTES FROM THE GYNECOLOGICAL SERVICE OF THE HOWARD HOSPITAL.

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Congenital Absence of the Vagina.—A young woman, married, was brought to the hospital by Dr. E. E. Neff, of Altoona, Pa., on account of congenital malformation of the vagina. On examination the

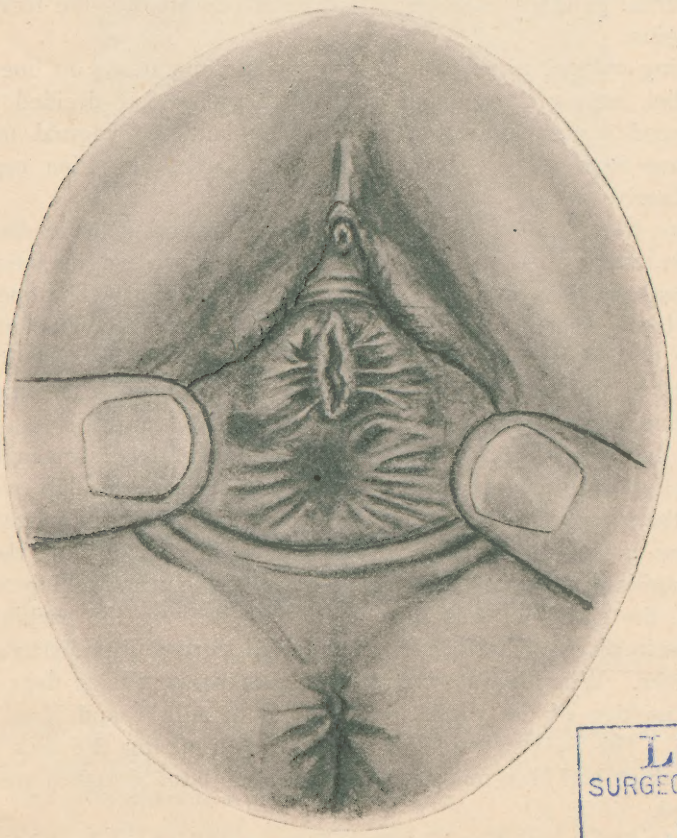

Fig. 1.—Congenital absence of the vagina

condition shown in Fig. 1 was seen. It was possible to push the forefinger between the rectum and bladder for a distance of more than an inch, by depressing the skin at the seat of what should have been the

vaginal entrance. By a combined examination with a finger in the rectum and pressure upon the abdominal walls, a body resembling the uterus could be felt in the pelvis, and to the right of it was apparently an ovary.

There had, of course, been no menstruation and no vicarious discharge. After marriage, however, there had been menstrual molimina, with a fair degree of regularity, associated with considerable pain in the lower abdomen. Coitus after marriage had been frequent, but the woman, according to her statement, experienced no sexual excitement. In view of the menstrual molimina, the physical signs of a uterus and an ovary, and the bare possibility of establishing a communication between the uterine cavity, should there be one, the ovary and the external genitalia, it appeared justifiable to attempt the formation of a vagina.

Being obliged to perform several plastic operations on one operating day, among them one for complete prolapse, I decided to try Mackenrodt's proposition,—namely, to implant the vaginal mucous membrane from the case of prolapse into the artificial vagina, made by blunt dissection.

Two broad and thick flaps of mucous membrane were dissected from the anterior and posterior walls of the prolapsed vagina, and were kept immersed in a warm sterile normal salt solution. The operation for prolapse was then rapidly completed. Next in the patient with absence of the vagina, a blunt dissection was made between bladder and rectum till the rudimentary uterus was reached. The mucous-membrane flaps were sewed loosely together with catgut, side by side, over a cylindrical speculum, so that they completely surrounded it. Two catgut sutures were passed from the edges of the flap over the end of the speculum, which was then packed with iodoform gauze. The speculum, covered by the flaps, was inserted three inches into the artificial vagina: pressure being made upon the gauze packing with a forceps, the speculum was then withdrawn, leaving the packing and the flaps in place. The former was allowed to remain undisturbed for two weeks. When it was removed the mucous-membrane flaps in the deeper portion of the vagina were found to adhere and bleed when pricked. The lower portion of the flaps overlapping the skin of the vulva, which had been pushed into the vagina, later sloughed and were extruded. (Fig. 2.)

The patient had been instructed to report to her physician regularly for a dilatation of the vagina, if there should be, as there always is in such cases, a disposition to contract. She failed to do so, however, and about six months after the operation the artificial vagina, according to Dr. Neff's statement, had again closed. But, curiously

enough, the patient and her mother declared that there had been a regular menstrual discharge after the operation, and they are both firmly convinced that the woman is now two months pregnant. She has much improved in health since the operation, being free from abdominal pain and putting on about twenty pounds in weight. It is the latter fact and the deposition of fat on the omentum and abdominal walls, no doubt, that has led her to believe herself pregnant. In the operation the uterus was found to be of fair size, to possess a well-defined curve, but no uterine cavity. This case has apparently met the fate of all attempts to establish an artificial vagina with rudimentary or absent

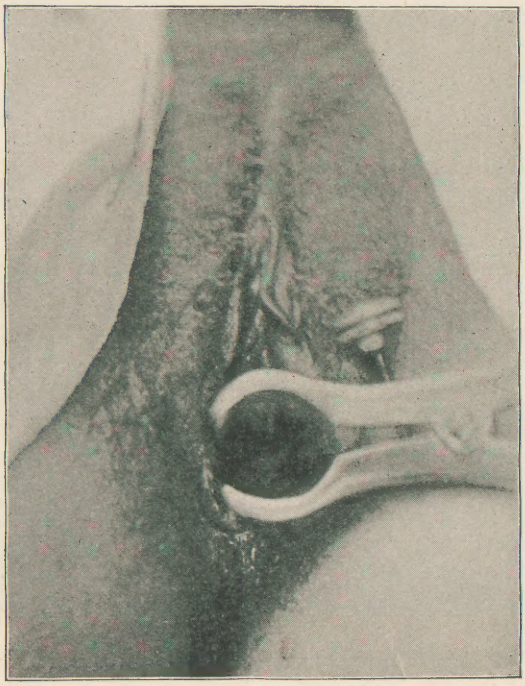

FIG. 2.—Three weeks after operation for artificial vagina and implantation of vaginal mucous membrame; speculum inserted three inches.

sexual organs. As a rule, such attempts are unjustifiable, but in this instance there seemed to be sufficient evidence of internal sexual organs fairly well developed to warrant the attempt.

Recto-Vulvar Fistula, probably due to Violence in Coitus.—The patient, aged 25 years, an Italian and single, was brought to the hospital by her *fiancé*, who claimed that another woman had told him his betrothed was deformed in her sexual organs. The woman herself, who could not speak English, and was not remarkable for intelligence, stated that her father had syphilis, and that she had her present trouble

ever since her birth. (Fig. 3.) On examination there was found, to one side of and below the hymen, an opening communicating with the rectum. It had nothing whatever in common with "anus vestibularis," but looked exactly like a case I saw some twelve years ago, in which the vulvo-rectal septum had been perforated at the first coitus, leaving an intact and thick hymen guarding the unpenetrated vagina. Coitus had taken place regularly for more than a year through this unnatural opening.

It is possible, of course, that the Italian woman might have had, in early childhood, an ulceration or abscess in the vulva, opening into the

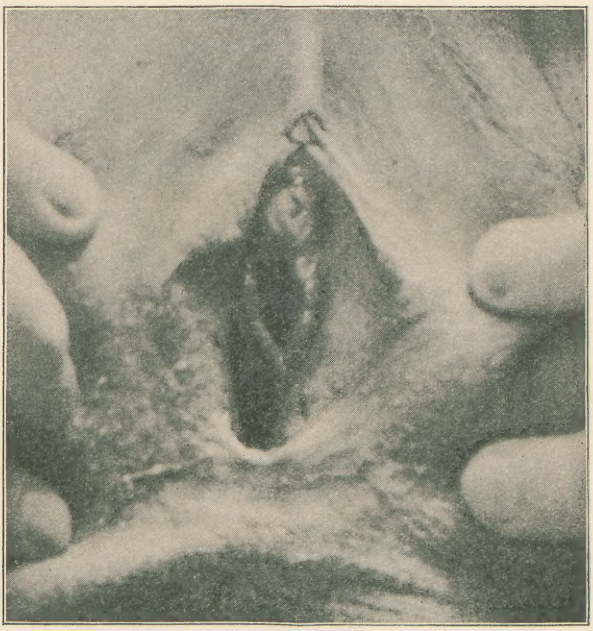

FIG. 3.—Vulvo-rectal fistula, probably due to violence in coitus.

bowel, but the appearance of the fistula and its situation strongly suggested violence in coitus.

During my absence, in the summer, the fistula was successfully closed by my assistant, Dr. W. F. Sprenkel.

Ovarian Cyst, infected and inflamed, removed in the Puerperium. —Mrs. M., delivered for the second time with forceps four weeks before her admission to the hospital, was discovered, two weeks after delivery, to have a large tumor in the upper part of the abdomen, supposed to be an abscess the result of infection. Her physician, Dr. J. V. Kelly, of Manayunk, on his return from a journey, found her in a very bad condition, and immediately sent her to the hospital. The patient had, on admission, high fever, rapid pulse, and was profoundly

reduced. She exhibited the appearance, on inspection, shown in Fig. 4. The vaginal examination was entirely negative, the tumor being far out of reach above the pelvis. At the operation a large ovarian cyst was discovered adherent to the liver and adjacent structures. It had evidently been carried to the upper abdomen by the ascent of the pregnant uterus, and had been fixed there by inflammatory adhesions. The uterus in its involution descended to a normal level, leaving the ovarian tumor in the upper half of the abdomen, but attached to the broad ligament by an enormously elongated pedicle. The removal of the tumor was difficult, but was rapidly accomplished, and the patient made an uncomplicated recovery. This case suggests the interesting question of the treatment of ovarian tumors complicating the childbearing process. From an experience of seven operations on six individuals, I should answer it at present as follows: Remove an ovarian cyst if discovered during pregnancy up to the fifth month; after that time, for fear of

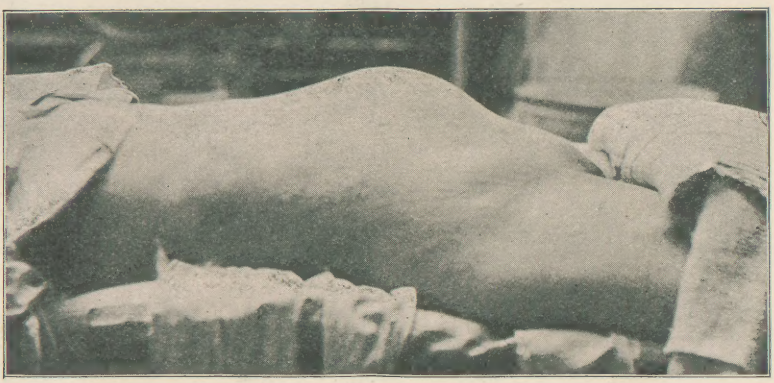

FIG. 4.—Multilocular ovarian cyst, removed four weeks after confinement.

exciting labor on top of an abdominal section, wait till term; disregard the tumor if it is out of the way; if it is in the lower genital canal push it out of the pelvis by gentle taxis; but if it obstructs labor and cannot easily be displaced, perform a coincident Cesarean section and ovariectomy. In the puerperium watch a patient with an ovarian cyst very carefully. On the first appearance of fever, rapid pulse, or abdominal pain, open the abdomen and remove the tumor, without waiting for indubitable evidence of the infection of the cyst. Late operations for this condition are very uncertain, the patient often dying of septic intoxication, although the suppurating cyst is removed whole, without rupture; early operations ought always to be successful. No matter how desperate the patient's condition, however, an attempt should be made to save her by operation. I have twice succeeded in late operations under apparently hopeless conditions.

Large Fibromyoma of the Uterus, simulating in Form, Consistency, and Clinical History an Ovarian Cyst.—The morphology of abdominal tumors is a useful study from the diagnostic view-point. I have a large collection of photographs of the different abdominal growths known to surgery, many of which are quite characteristic in form. But occasional exceptions to the rule may easily lead an experienced observer astray unless he is constantly on his guard. Fig. 5 is a good illustration of this fact. Mrs. B., a patient of Dr. William H. Crane, of Philadelphia, was 42 years of age, with five children. Her menstruation had always been regular, lasting three days and scanty. She had never had metrorrhagia or menorrhagia. Four years ago she first noticed an abdominal enlargement, which rapidly increased. For the year preceding her operation she had been incapaci-

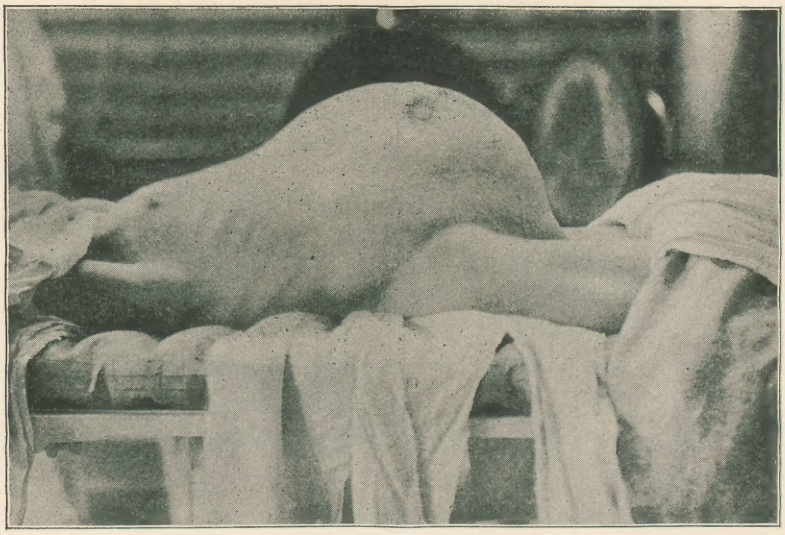

FIG. 5.—Large multilocular fibroma, showing characteristic emaciation of patient.

tated by the weight and pressure of the abdominal tumor. Her emaciated appearance, the spherical form of the tumor and its consistency suggested strongly an ovarian cyst, but the operation proved it to be a large intramural fibromyoma weighing nearly thirty pounds. The woman made a perfect recovery.

Tubal Gestation advanced to the Fourth Month, and retained Unruptured in the Abdomen for Seven Months.—Mrs. B., aged 34, married nine years, never before pregnant. Last normal period in April, 1898. In June a slight bloody discharge followed by excruciating abdominal pain, lasting eight hours. A week later another exacerbation of pain; for the next six weeks there were attacks of pain every two or three days, completely disabling her. The flow continued

for *five months,* the greater part of the time as a muddy discharge. In November a severe uterine hemorrhage occurred, followed by a profuse flow, lasting two weeks. In the following months the periods were practically normal. The patient finally came under the observation of Dr. J. M. Brown, of Philadelphia, who made the correct diagnosis. On examination a large solid tumor was felt to the right of the uterus and adherent to it. (Fig. 6.) When the abdomen was opened there was no trace of intraperitoneal hemorrhage, and the gestation sac showed no evidence of rupture. The abdomen was closed without drainage, and the patient made an uncomplicated recovery. The in-

FIG. 6.—Removal of tube and four months' fetus.

terest of this case lies mainly in frequent exacerbations of severe and characteristic abdominal pain, without rupture of the sac or intraperitoneal bleeding. In the complete notes of thirty-five cases in my case-books, while pain is often the predominant factor and does not always indicate a rupture with hemorrhage, there is no other case of pure tubal pregnancy in which so many exacerbations over such a long period of time, showing tremendous strain on the tubal wall, were not followed by actual laceration and some bleeding. In this particular, I think, the case must be a very rare one.